



Emergency Medical Services Community EMS Assistance Program

1. _____ County 2. _____ Date of Application

3. Project Grant Period:

From: _____ 4. 1 Year _____ 2 Years _____
To: _____

	Amount	
5. State Funds Requested	\$ _____	Source of Local Funds
Total Local Cash	\$ _____	
Total Project Cash	\$ _____	<input type="checkbox"/> County <input type="checkbox"/> Community <input type="checkbox"/> Private

6. Ambulance Service:

Name	Address	Telephone
_____	_____	_____
Director/Chief/Name		Signature

7. County Authorization:

Choice of Funding Formula

The county has chosen a local formula for distribution of monies among the ambulance service and all the services have agreed in writing on this formula. The documentation of their agreement with signatures is attached.

If yes, initial here: _____

The county has chosen to fund each of the ambulance services based on the percentage of the county's total emergency runs which were run by each ambulance service.

If yes, initial here: _____

I certify that I understand and agree to comply with the general and fiscal requirements of this application and that I am duly authorized to commit the applicant to these requirements. I also understand that the funds available through this grant are not to be used to replace existing dollars now used for the EMS program. A reasonable effort has been made to inform all eligible services of the opportunity to apply for EMS assistance through this grant program.

Authorizing Official

County	Name	Title
_____	_____	_____
Street	City	Zip
_____	_____	_____
Signature	Date	

8. Review and Approval:

Regional EMS Agency: _____
Region _____
Signature _____ Title _____
Date: _____

Community EMS Assistance Program**1. Basic Life Support Equipment**

Quantity	Item	Total

BLS Total \$ _____

2. Advanced Life Support Equipment

Quantity	Item	Total

ALS Total \$ _____

3. Extrication Equipment

Quantity	Item	Total

Ext. Equip. Total \$ _____

4. Communications Equipment

Quantity	Item	Total

Communications Equipment Total \$ _____

5. Training

Quantity	Item	Total

Training Total \$ _____

6. Other/Describe (Ambulance)

Quantity	Item	Total

Other Totals \$ _____

Budget Justification

Please state, in a concise manner, specifically how each item of equipment or each training course that you have requested will provide improved patient care in your area. State how many items you now have and why you need more. (i.e. We have five ambulances, four at the ALS level and wish to upgrade the fifth ambulance to ALS and need a defibrillator and four paramedic tuitions)

Be as complete as possible to avoid any confusion to decrease the need for additional justification. Attach extra pages, brochures, vendor literature (**only** on items that are unusual/innovative) to explain.

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slightly textured appearance and some minor discoloration or shadows, particularly along the left edge where it might have been bound. The overall tone is light gray, typical of a scanned document.

EMS Recipient Agency Information

Name: _____

Address: _____

City: _____ County: _____ Zip Code: _____

Emergency Telephone: _____ Business Telephone: _____

Total Number of Ambulances: _____ Ambulances Manned 24 Hours Per Day: _____

Total Number of Ambulance Calls Annually: Emergency _____ Convalescent _____

Are patients provided service without prior inquiry regarding ability to pay? ☐ yes ☐ no

Describe Primay Service Area: _____

Are there written mutual aid agreements with all adjacent EMS organizations? ☐ yes ☐ no

Current Rate Structure: Base Rate \$ _____ Mileage Charge (One Way) \$ _____

Will this ambulance conform to the State ambulance allocation plan, and is it an essential vehicle to the applicant agency? ☐ yes ☐ no

Does the applicant agency operate within the guidelines of the State EMS system? ☐ yes ☐ no

Has the Regional Board of Directors reviewed this project? ☐ yes ☐ no

Has the project been recommended for funding? ☐ yes ☐ no

Comments: _____

Vehicle to be Replaced

Vehicle Location: _____

☐ Type I ☐ Type II ☐ Type III ☐ Commercial Ambulance Body

Other (Describe): _____

Make: _____ **Year Model:** _____ **Mileage:** _____

Serial Number: _____ **License Number:** _____

Current DHEC Permit Number: _____

Current Liability Insurance Limits:

☐ \$50,000 - \$100,000 ☐ \$100,000 - \$300,000 ☐ \$100,000 - \$500,000

Collision to Cover Actual Market Value of Vehicle: ☐ yes ☐ no

Deductible (Collision) ☐ \$50.00 ☐ \$100.00 ☐ \$250.00 ☐ \$500.00 **Other:** _____

Company: _____ **Local Agent:** _____

Agent Address: _____ **Telephone Number:** _____

Disposition of Vehicle: _____

Vehicle Requested:

Type: _____ **Make:** _____ **State Contract:** _____

Options: See State Contract and List with Indicated Contract Price

_____	\$	_____
_____	\$	_____
_____	\$	_____
_____	\$	_____

Vehicle Location: _____

Utilization: ☐ Emergency Only ☐ Emergency and Convalescent

Estimated Number of Ambulance Calls in First Year of Operation: _____